South Central CT Substance Abuse Council

Epidemiologic Profile of Substance Use, Suicide & Problem Gambling

January 2013

Contributors

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Abbreviations and Terms

CNAW	Community Needs Assessment Workgroup: local resource group to inform the sub regional epidemiologic profile process.
DMHAS	CT Department of Mental Health and Addiction Services
Hispanic or Latino Origin	Hispanics or Latinos who identify with the terms “Hispanic,” “Latino,” or “Spanish” are those who classify themselves in one of the specific Hispanic, Latino, or Spanish categories that may be listed (“Mexican,” “Puerto Rican,” or “Cuban”) as well as those who indicate that they are “another Hispanic, Latino, or Spanish origin.” People who do not identify with one of the specific origins listed in questionnaires but indicate that they are “another Hispanic, Latino, or Spanish origin” are those whose origins are from Spain, the Spanish-speaking countries of Central or South America, or the Dominican Republic. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.
Incidence	The number of new cases in a defined population in a certain time period that is used to measure frequency.
Mortality	The total number of persons who have died of the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole.
Race	The racial classifications used by the Census Bureau adhere to standards issued by the federal Office of Management and Budget. OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race and that respondents should be offered the option of selecting one or more races. If an individual did not provide a race response, the race or races of the householder or other household members were imputed using specific rules of precedence of household relationship.
NSDUH	National Survey on Drug Use and Health. This national survey often used as the benchmark for national and state data comparisons.
NHTSA - FARS	National Highway Traffic Safety Administration, Fatal Accident Reporting System. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.
Poverty Status	To determine a person's poverty status, one compares the person’s total family income in the last 12 months with the poverty threshold appropriate for that person's family size and composition. If the total income of that person's family is less than the threshold appropriate for that family, then the person is considered “below the poverty level,” together with every member of his or her family. If a person is not living with anyone related by birth, marriage, or adoption, then the person's own income is compared with his or her poverty threshold. The total number of people below the poverty level is the sum of people in families and the number of unrelated individuals with incomes in the last 12 months below the poverty threshold.
Rate	A measure of the frequency of the disease, behavior of event compared to the number of persons at risk for it. The general population is used as the denominator in this report. The size of the population is based on census data. The multiplier (100,000) is used to convert the resulting fraction to number of cases per 100,000 population. This is standard practice in epidemiology.

SCCSAC	South Central Connecticut Substance Abuse Council (formerly Meriden and Wallingford Substance Abuse Council – MAWSAC) The regional action council for Sub region 2A covering the municipalities of Branford East Haven, Guilford, Hamden, North Branford, North Haven, Madison, Meriden, Wallingford
South Central Region	This area encompasses the sub regional RAC councils of SCCSAC, VSACC and MCSAAC covering greater New Haven, the Ansonia/Derby valley area and Middlesex County.

Executive Summary

In response to a request from the CT Department of Mental Health and Addiction Services, the South Central CT Substance Abuse Council conducted a process of data collection, analysis and community input to produce the 2012 Epidemiological Profile of Substance Use, Suicide and Problem Gambling for the sub region. Municipalities in the sub region are Branford, East Haven, Guilford, Hamden, North Branford, North Haven, Madison, Meriden and Wallingford.

A Community Needs Assessment Workgroup (CNAW) was convened to review the current data and rank order the eight substances and behaviors studied. The topic areas were alcohol, tobacco, marijuana, prescription drug misuse, heroin cocaine, problem gambling and suicide. The areas were ranked according to magnitude, impact and changeability.

Overall, Alcohol was ranked the number 1 priority in the sub region, which has been the case for the last four years. The sub region has a number of PFS grantees, Drug Free Community programs and Local Prevention Councils that have and are continuing to address alcohol misuse with particular emphasis on the youth population. The magnitude and changeability of the problem was ranked higher than all other substances/behaviors. Only Prescription Drug Misuse was ranked higher in Impact to the sub region. The abuse of alcohol and the consequences to the individual, family and community continue to be the first concern of the sub region.

Prescription drug misuse has been the emerging concern of the region for the past two years. The use of painkillers (notably OxyContin) has been noted by CNAW members and treatment providers as a “gateway” drug for many youth who become addicted quickly to the opiate based drug. When the cost of the pills becomes prohibitive, users often move to heroin, which is less expensive and produces the same type of “high”. Heroin overdoses have reached unprecedented levels in the sub region. CNAW members noted that addressing the alcohol, prescription drug and marijuana use by youth in the sub region (particularly the pill use) could have an effect on reducing the number of addicts who move on to heroin as their need for the drugs increases.

Marijuana continues to be a major concern for the sub region CNAW members who noted that recent changes in the law on decriminalization and the prescribing of medical marijuana has created a challenge in working with youth who see these changes as pro-marijuana. Several sub regional coalitions have added marijuana as a second substance to address in their work (underage alcohol use being the first substance).

Tobacco use has dropped in the priority rankings. While CNAW members continue to address tobacco issues, societal acceptance of the dangers of smoking and the changes in laws have done much to change the culture of cigarette use. Disturbingly, youth report that they perceive marijuana as far less dangerous than tobacco.

Suicide rates and attempts continue to be discussed in the sub region. Within the past year statewide efforts have begun to train local staff to present prevention and intervention programs. The CNAW is hopeful that these efforts will address these concerns.

The areas of problem gambling and cocaine use continue to be ranked as the lowest priorities in the sub region. Cocaine use is not perceived as widespread. Problem gambling and the linkage to other addictive behaviors are addressed in SCCSAC initiatives.

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Introduction

Purpose of the profile

The purpose of the Sub regional Epidemiological Profile is to describe 1) the burden of substance abuse, problem gambling and suicide in the sub region; 2) the prioritized prevention needs, and 3) the capacity of the communities in the sub region to address those needs. The report is based on a data-driven analysis of issues in the sub region with assistance from key community members.

The report and accompanying data will be used as a building block for state and community-level processes, including capacity and readiness building, strategic planning, implementation of evidence-based programs and strategies, and evaluation of efforts to reduce substance abuse and promote mental health. In addition, this data will form the core of the RAC's sub regional data repository. In this role, SCCSAC will take every opportunity to publicize the availability of town level data on various indicators, engage other organizations in gathering and sharing data, and will provide data on various indicators to the community.

Description of the RAC region

South Central CT Substance Abuse Council (SCCSAC formerly know as MAWSAC) is one of fourteen sub regional action councils in CT. The SCCSAC sub region consists of the municipalities of Branford, East Haven, Guilford, Hamden, Madison, Meriden, North Branford, North Haven and Wallingford. The diversity of the sub region is most notable in the following selected categories:

	Population	Hispanic %	White, Non-Hispanic %	Black and African American, Non-Hispanic %	Asian, Non-Hispanic %	Median Earnings Past 12 Months, 25 yrs and older	% Below Poverty Level
Branford	28,026	4.1	89.0	1.8	3.6	$ 47,678	5.8
East Haven	29,257	10.3	82.5	2.6	3.3	$ 41,248	8.3
Guilford	22,375	3.5	92.2	0.7	2.4	$ 53,028	2.8
Hamden	60,960	8.7	64.1	19.5	5.4	$ 45,939	6.8
Madison	18,269	2.1	93.9	0.5	2.2	$ 60,405	0.7
Meriden	60,868	28.9	58.8	8.2	2.1	$ 38,490	13.8
North Branford	14,407	2.9	93.2	1.3	1.6	$ 48,336	0.7
North Haven	24,093	3.9	87.4	2.9	4.7	$ 48,208	3.9
Wallingford	45,135	7.9	86.1	1.3	3.4	$ 44,548	6.8
SCCSAC Region	**303,390**	**10.9**	**77.5**	**6.5**	**3.4**	**$78,089**	**7.1**

Source: 2008-2010 American Community Survey CT Estimates, prepared by the U.S. Census Bureau, 2011. Table 1

Sources of data

Census Data

Definitions

Age: The age of the person in complete years at the time of census interview.

Sex: Individuals mark either "male" or "female" to indicate their biological sex.

Race: The racial classifications used by the Census Bureau adhere to standards issued by the federal Office of Management and Budget. OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race and that respondents should be offered the option of selecting one or more races. If an individual did not provide a race response, the race or races of the householder or other household members were imputed using specific rules of precedence of household relationship.

Hispanic or Latino Origin: Hispanics or Latinos who identify with the terms "Hispanic," "Latino," or "Spanish" are those who classify themselves in one of the specific Hispanic, Latino, or Spanish categories listed on the questionnaire ("Mexican," "Puerto Rican," or "Cuban") as well as those who indicate that they are "another Hispanic, Latino, or Spanish origin." People who do not identify with one of the specific origins listed on the questionnaire but indicate that they are "another Hispanic, Latino, or Spanish origin" are those whose origins are from Spain, the Spanish-speaking countries of Central or South America, or the Dominican Republic. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

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Source: 2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.

Arrests for Driving Under the Influence

Definition: Arrests recorded for driving or operating any motor vehicle or common carrier while drunk or under the influence of liquor or narcotics.

Source: Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths: Driving under the influence (DUI) is a direct consequence of alcohol or drug misuse. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations: Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies that participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Arrests for Liquor Law Violations

Definition: Arrests recorded for possession of alcohol by minor, sale or provision of alcohol to minors, or fake/false identification. Does not include public drunkenness, driving under the influence or administrative actions taken by the Department of Consumer Protection Liquor Control Commission against liquor permittees.

Source: Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths: Liquor law violations are a direct consequence of alcohol misuse. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations: Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies that participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Arrests for Drug Law Violations

Definition: Arrests related to narcotic drugs, such as unlawful possession, sale, use, growing and manufacturing of narcotic drugs.

Source: Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths: Narcotic drug law violations are a direct consequence of drug use. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations: Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies that participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Alcohol-Involved Motor Vehicle Accidents

Definition: Alcohol-involved motor vehicle accidents.

Source: Connecticut Department of Transportation Traffic Accident Viewing System.

Strengths: Alcohol motor vehicle involved accidents are a direct consequence of alcohol misuse. The information is routinely collected as part of the Department of Transportation's Traffic Accident Viewing System.

Limitations: The rates may underestimate the actual occurrence due to underreporting. A person involved in an accident in particular town may not reside in that town.

Fatal Motor Vehicle Accidents while Under the Influence of Alcohol or Drugs

Definition: Motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00) or was reported to be under the influence of drugs.

Source: National Highway Traffic Safety Administration (NHTSA), Fatal Accident Reporting System (FARS)

Strengths: Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations: Alcohol Test Result statistical data obtained from this database should be interpreted with caution. Alcohol Test Results included in this database are actual state-reported data. Estimates obtained by use of this query system may differ from NHTSA's published reports. NHTSA's published estimates are based on data from the Fatality Analysis Reporting System (FARS). Unfortunately, known BAC test results are not available for all drivers and non-occupants involved in fatal crashes. "Property Damage Only" accidents, which occurred on locally maintained roadways from 01/01/2007 to the present are included in the DOT accident file; prior to that date, they were not included in the file. The rates may underestimate the actual occurrence due to underreporting, and also a person involved in an accident in particular town may not reside in that town.

Motor Vehicle Accident Fatalities while Under the Influence of Alcohol or Drugs

Definition: Total fatalities in motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00) or was reported to be under the influence of drugs.

Source: National Highway Traffic Safety Administration (NHTSA), Fatality Analysis Reporting System (FARS)

Strengths: Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations: This indicator may be unstable for less populated areas that have low numbers of annual fatal crashes. While considerable effort has been made to obtain the BAC values for all drivers involved in fatal crashes, these data are not complete. Therefore, NHTSA estimates driver BAC for cases missing data.

Lung Cancer Deaths

Definition: Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes C34 as the underlying cause of death

Source: Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=3881

Strengths: Eighty to 90% of all lung cancer is attributable to cigarette smoking. Data on lung cancer deaths are readily available for many years.

Limitations: Death from lung cancer reflects long-term, chronic cigarette smoking, and lung cancer has a long latency period. Therefore, it may be many years before changes in smoking affect population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur and may be unstable for less populated states or when used for demographic subgroups. There also is variability in the procedures used within and across each state to determine cause of death.

Alcohol Attributable Chronic Liver Disease and Cirrhosis Deaths

Definition: Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes K70, K73, or K74 as the underlying cause of death.

Source: Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths: Long term, heavy alcohol consumption is the leading cause of chronic liver disease, in particular cirrhosis, one of the 12 leading causes of death. According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 40% of deaths from cirrhosis in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations: This indicator is only based on deaths; cases of cirrhosis morbidity are not reflected in this indicator. Alcohol-related cirrhosis may have a long latency; there may be a lag of several years between changes in behavior and population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur. Therefore, this indicator may be unstable for less populated states and counties that have low numbers of annual deaths, especially when used for demographic subgroups.

Alcohol Attributable Suicides

Definition: Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X60-X84,Y87.0 as the underlying cause of death.

Source: Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths : According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 23% of suicides in Connecticut were attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations: The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as suicide, are best used at the state or regional levels.

Alcohol Attributable Homicides

Definition: Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X85-Y09 and Y87.1 as the underlying cause of death. Homicide includes injuries inflicted by others that result in death.

Source: Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths: According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 47% of homicides in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations: The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as homicide, are best used at the state or regional levels

Alcohol-induced Death

Definition: Alcohol-induced deaths include alcohol-induced pseudo-Cushing's syndrome; mental and behavioral disorders due to alcohol use; degeneration of nervous system due to alcohol; alcoholic polyneuropathy; alcoholic myopathy; alcoholic cardiomyopathy; alcoholic gastritis; alcoholic liver disease; alcohol-induced acute pancreatitis; alcohol-induced chronic pancreatitis; finding of alcohol in blood; accidental poisoning by and exposure to alcohol; intentional self-poisoning by and exposure to alcohol; and poisoning by and exposure to alcohol, undetermined intent. Alcohol-induced causes exclude accidents, homicides, and other causes indirectly related to alcohol use, as well as newborn deaths associated with maternal alcohol use.

Source: Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths: These deaths are a direct consequence of alcohol misuse.

Limitations: The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

Drug-induced Death

Definition: Drug-induced deaths include all deaths for which drugs are the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. A drug includes illicit or street drugs (e.g., heroin or cocaine), as well as legal prescription drugs and over-the-counter drugs; alcohol is not included. The majority of deaths are unintentional drug poisoning deaths, with suicidal drug poisoning and drug poisoning of undetermined intent comprising the majority of the remainder. Adverse effects from drugs taken as directed and infections resulting from drug use are not included. In 2007, drug-induced deaths were more common than alcohol-induced or firearm-related deaths in the United States.

Source: Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths: These deaths are a direct consequence of drug misuse.

Limitations: The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

Alcohol and Other Drug Related School Suspension or Expulsion

Definition: A sanction determined the school administration due to violation of a publicized policy; or serious disruption of the educational process; or endangerment to persons or property.

Source: Connecticut State Department of Education disciplinary offense records

Strengths: Students who use alcohol, tobacco or other drugs at an early age and use substances frequently are more likely than other students to continue to face suspension or expulsion. These data are based on uniform definitions applied to all schools in the state and, therefore, have comparative values.

Limitations: The definition for counting drug or alcohol disciplinary offense is uniformly defined statewide. However, the specific data collection requirements have changed in recent years. Therefore, these data are not necessarily comparable across years. The data should be used with discretion.

Overall School Attendance in Past Year

Definition: Overall school attendance is the number of students attending public school each day of the school year, divided by the number of days that school was in session during the school year.

Source: Connecticut State Department of Education. School attendance record

Strengths: Researchers have found that truancy itself seems to contribute to or at least correlate with a diverse array of problems among young people. Studies have established lack of commitment to school and truancy as risk factors for substance abuse, teen pregnancy, delinquent behavior, and school dropout.

Limitations: This indicator is an indirect measure of substance abuse and its consequences

Tobacco Retailer Violation

Definition: Tobacco retailers who sold tobacco to minors working undercover for the CT DMHAS Tobacco Prevention and Enforcement Program.

Data Source: Connecticut Department of Mental Health and Addiction Services Tobacco Prevention and Enforcement Program

Strengths: Tobacco use by minors is a consequence of access to tobacco products. The Synar Amendment requires states and U.S. jurisdictions to have laws and enforcement programs for prohibiting the sale and distribution of tobacco to persons under 18. As a result, over the last 14 years, data reported by states and the District of Columbia has indicated a clear downward trend towards reducing tobacco sales to minors. Data on retailer violations have been systematically collected by DMHAS for many years.

Limitations: This indicator may be unstable for areas or subgroups that have small population sizes, which are not routinely subject

Strengths and Limitations of the Profile

Limitations:

A complete and thorough analysis of the areas of problem gambling and cocaine use was hampered by the lack of substantive data.

It should be noted that the priority ranking process is influenced by and limited to the opinions of those CNAW members in attendance.

Arrest record data may be skewed for particular towns, for example a person arrested in one town may reside in another.

School survey data for municipalities in the SCCSAC region are not available for all sites.

Strengths:

CNAW participation generated lively discussions and anecdotal information provided a clearer picture of what communities are facing today.

Data provided by DMHAS for town level statistics was extremely helpful

Methods

The priority setting process included the collection of national, state, regional and town level data on the identified substances/behaviors identified by DMHAS staff as pertinent to the 2012 report process. Sub regional socio-demographic and indicator data using data provided by the SEOW and additional community-level data where available was used as a basis for this report.

A Community Needs Assessment Workgroup (CNAW) was convened to review data and information from national, state and local resources. Using the Priority Rating Matrix provided by DMHAS, each CNAW member scored each problem on a scale of one to five (low to high priority) using the following criteria: 1) Magnitude (burden and breadth of problem, number of people affected, and number affected is sufficient to assess statistically significant change over time); 2) Impact (depth of problem access dimensions, health, economic, criminal justice costs); 4) Changeability (the indicator is amenable to change, resources and evidence-based strategies are available to affect change in the indicator). Community members who were unable to attend the two CNAW meetings were given the opportunity to submit their

ranking matrix after receiving all of the statistical data table and the draft sub regional profiles. SCCSAC compiled all of the scores to determine the average priority ranking for each substance/behavior.

CNAW Priority Ranking Matrix - Aggregate Scores

SCALE: 1=Lowest 2=Low 3=Medium 4=High 5=Highest

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	TOTAL
Alcohol	4.33	4.07	3.83	12.23
Tobacco	2.8	2.73	3.43	8.97
Marijuana	3.63	3.60	3.53	10.77
Prescription Drug Misuse	3.87	4.13	3.53	11.53
Heroin	3.17	3.62	3.17	9.97
Cocaine	2.48	3.07	3.14	8.69
Problem Gambling	2.33	2.56	2.44	7.33
Suicide	2.78	3.33	2.89	9.00

Overall Ranking for 2012	Overall Ranking from 2010
#1 Alcohol	#1 Alcohol
#2 Prescription Drug Misuse	#2 Marijuana **
#3 Marijuana	#2 Prescription Drug Misuse **
#4 Heroin	#2 Suicide **
#5 Suicide	#3 Tobacco
#6 Tobacco	#4 Heroin
#7 Cocaine	#5 Problem Gambling
#8 Problem Gambling	#6 Cocaine

** Overall scores were tied for these 3 issues in 2010, however it is significant that Prescription Drug Misuse was viewed as having a low impact in the region; marijuana was seen as having a low changeability number; and Suicide was seen as having a much larger magnitude.

South Central CT Substance Abuse Council

Alcohol

Magnitude

Alcohol is the most commonly used substance nationally and statewide. According to NSDUH data from 2008-2010 past month use of alcohol in CT and the South central region significantly exceed the national averages.

% Averages	**Total U.S.**	**CT**	South Central Region
Past Month Use for Ages 12-17	14.41	18.18	20.27
Past Month Use for Ages 18-25	61.22	68.22	70.52
Past Month Use for Ages 26 and older	54.72	63.29	64.50

Source: NSDUH Table 2

Similarly, binge drinking within the past month for CT and the South central region of the state exceed the national averages for all age categories.

Alcohol abuse continues to be of concern in the sub region as in all of Connecticut. CNAW members noted that the social acceptance of youth drinking has changed somewhat but there are still issues with parental acceptance of underage use of alcohol. One CNAW member reported that when checking on her underage daughter attending a house party of a friend, she called the parent. The parent quickly said that yes the parent would be in the home during the party and there would be no drugs allowed. When asked about alcohol, the parent said that "of course there will be alcohol, the kids said we need to have that."

Consequences

Alcohol related school suspensions (reported as the percentage of all suspensions for each academic year) show a variation by municipality and should be viewed in tandem with the chart detailing illegal drug related suspensions.

% of all suspensions attributed to alcohol	**2006-2007**	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**
CT	**21**	**20**	**19**	**21**	**17**
Branford	33	56	52	53	20
East Haven	6	13	10	17	4
Guilford	23	18	33	50	11
Hamden	5	35	16	24	16
Madison	41	29	15	17	24
Meriden	11	4	13	22	18
No. Branford	21	8	8	0	0
No. Haven	10	26	6	8	14
Wallingford	38	6	6	42	47
ACES Coop	unk	43	0	8	7
CT Tech HS	0	17	45	0	0
Highville Charter	0	0	0	0	0

Source: CT State Dept. of Education Table 3

Liquor law arrest data from 2005 to 2010 indicates that the majority of towns in the sub region experienced a decrease in the number of violations, from a high of 150 in the sub region in 2005 to 44 in 2010. The increase in focus on underage access to alcohol may contribute to increased enforcement.

Alcohol involved motor vehicle accidents:

	Rate per 100,000 2005	**2006**	**2007**	**2008**	**2009**	**2010**
CT	**5.5**	**5.2**	**7.15**	**6.9**	**6.7**	**6.6**
SCCSAC	**5.7**	**5.4**	**7.1**	**8.2**	**6.8**	**6.5**
Branford	6.3	5.2	5.93	9.4	11.2	8.7
East Haven	6.0	4.3	4.61	5.7	5.3	5.3
Guilford	7.0	3.7	7.01	6.1	5.6	8.4
Hamden	2.6	2.8	5.45	6.3	4.2	3.0
Madison	7.8	5.6	7.28	5.6	5.6	6.7
Meriden	4.5	6.2	7.04	7.4	5.5	7.7
No. Branford	4.3	2.9	2.88	2.9	2.9	2.2
No. Haven	**9.1**	**8.7**	**12.6**	**13.0**	**8.2**	**9.6**
Wallingford	**7.7**	**8.6**	**10.2**	**13.7**	**11.9**	**7.4**

Source: FARS, NHTSA Table 4

Data shows that while some of the towns in the sub region have trended down from 2005-2010 (East Haven, Madison,

and No. Branford) in the rate of alcohol involved motor vehicle

accidents, other towns have remained consistently higher than the statewide rate (North Haven, Wallingford).

Alcohol induced deaths are tracked by the CT Department of Public Health and point out municipalities in the sub region that are above the overall CT rate per 100,000 persons average. Given the variation of size in the communities in the sub region, even one death in a small community may greatly influence the % reported, however when taken as an overall indicator of the impact of alcohol on the community it is significant.

	1999-2001	**2002-2004**	**2005-2007**	**2007-2009**
CT	**5.1**	**5.3**	**5.3**	**6.1**
Branford	3.5	5.8	5.8	8.1
East Haven	2.4	3.5	1.2	4.7
Guilford	3.1	4.7	4.7	3.1
Hamden	3.5	5.3	1.8	5.3
Madison	1.9	1.9	1.9	1.9
Meriden	9.2	9.2	6.9	6.9
No. Branford	0.0	4.8	0.0	4.8
No. Haven	2.9	7.2	5.8	4.3
Wallingford	1.5	5.4	4.6	7.0

Source: CT DPH Mortality Statistics Table 5

Long-term heavy consumption of alcohol is the leading cause of chronic liver disease and cirrhosis, According to 2001-2005 data from the CDC, 40% of deaths from cirrhosis in CT are attributable to alcohol use. In the 1999-2009 data from the CT Department of Public Health, 256 persons in the SCCSAC sub region died from chronic liver disease. Therefore it suggests from the CDC formula that approximately 102 persons in the sub region died because of alcohol related disease and more than half of that number were from three municipalities (Hamden, Meriden and Wallingford).

Capacity to address the Problem

With respect to teen alcohol consumption, local collaborations do address the issue. School chapters of SADD and the Youth Service Bureau Peer Advocates are working with teens on a variety of issues, which recently have included driving and alcohol use.

The region is fortunate to have five Partnerships for Success grantees who are directing much of their efforts to address underage alcohol use and prevention. The towns of East Haven, Madison, Meriden, Hamden, and Branford are actively working with DMHAS in developing strategic plans for implementation of local initiatives.

TIPS (Training Intervention Procedures) classes for alcohol permittees are held in the sub region by the Regional Action Council. The Wallingford Police Dept. is also active in working with retail establishments.

Regular compliance checks are conducted in the sub region. The local prevention councils in the sub region conduct a large number of positive youth development programs.

According to the Priority Ranking Matrix completed by CNAW participants Alcohol ranked the highest in Magnitude and Changeability of all of the substances/behaviors. It ranked only slightly lower than Prescription Drug Misuse in the Impact on the community. Alcohol misuse and abuse continues to be the number 1 area of concern in the sub region across the lifespan, with particular emphasis on the 16 to 25 year old population.

Tobacco

Magnitude

According to data from the annual averages from 2008-2010 NSDUH surveys, the South Central region of CT has similar usages of tobacco products and cigarette use in the past month for ages 18 and older. Usage of tobacco products and cigarettes in the past month are somewhat higher than state averages during the same period for the 12-17 year old category.

The NSDUH data suggests that the highest tobacco product and cigarette use is in the 18 to 25 year age group, which is consistent with national data. Percentage of use in all other ages categories range between 8.77 to 25.03.

AGES 18-25	Tobacco product use in past month	Cigarette use in past month
Total U.S.	41.43	35.46
Northeast U. S.	41.18	35.54
Connecticut	41.22	35.80
South Central CT	40.19	34.05

Source: NSDUH 2008-2010 Table 6

In compliance with the national SYNAR program, the DMHAS Tobacco Prevention and Enforcement Program conducts retailer compliance inspections. Date from 2004-2010 reflects the following percentages for non-compliant retailers (sales to minors) who were inspected in a particular year:

%	2002-2004	**2005-2007**	**2008-2010**
CT	18.9	**14.0**	**13.3**
SCCSAC	**18.4**	**15.6**	**14.4**
Branford	28.3	10.8	13.3
East Haven	12.5	8.8	16.7
Guilford	25.3	12.9	14.8
Hamden	18.7	19.0	14.6
Madison	12.3	10.5	11.1
Meriden	23.0	23.9	14.4
No. Branford	7.6	5.9	17.9
No. Haven	15.4	16.2	16.4
Wallingford	16.7	13.5	10.2

Source: CT DMHAS Table 7

It should be noted that while each municipality was inspected the number of retailers differed each year due to time availability and personnel. This fluctuation can affect the percentage rate of non-compliance, however, as the CT non-compliance rate dropped from 2002-2010, the majority of municipalities in the sub region also saw a decrease in retailer sales of tobacco to minors.

Consequences

In CT, more than 5,400 people annually die from smoking-related diseases. Smoking increases the risk of heart disease, cancer, stroke and chronic lung disease. Heart disease is the leading cause of death in the US and in CT, and the leading cause of heart disease is smoking. Lung cancer deaths, taken as an indicator of tobacco impact on the population, show that the majority of the towns in the sub region have higher rates of death than the CT statewide rates from 1999-2009. Of note are the towns of East Haven and Branford that have consistently high numbers of death due to lung cancer.

Rate per 100,000 of deaths due to lung cancer:

	1999-2001	2002-2004	2005-2007	2008-2009
CT	**53.7**	**51.4**	**51.4**	**49.9**
SCCSAC				
Branford	**63.9**	**70.8**	**65.0**	**69.7**
East Haven	**72.1**	**81.5**	**93.4**	**85.1**
Guilford	45.1	57.5	62.2	49.7
Hamden	55.1	59.2	59.8	56.9
Madison	40.8	42.7	66.8	52.0
Meriden	61.2	52.1	56.1	52.6
No. Branford	79.0	55.1	62.3	45.5

No. Haven	43.3	63.5	63.5	60.6
Wallingford	51.8	56.5	45.6	47.9

Source: CT Dept. of Public Health Mortality Statistics Table 8

Capacity

At the statewide level CT residents do have access to smoking information and cessation assistance through a free statewide quit line. Laws enacted in the state in the last several years including smoke free restaurants and bars, and the increase in taxes on tobacco products have kept the issue of health impacts in the forefront. It will take several years to assess the impact of prevention and cessation programs on the death rate attributed to smoking and tobacco products. The rate of lung cancer has dropped slightly in some of the municipalities in the region, however the damage has already been done for many of the over age 60 population.

Recent changes in FDA regulations concerning the sale of tobacco products and the state law concerning possession of tobacco products by minors are areas that are currently being explored by local coalitions and the statewide

MATCH coalition. Opportunities for local prevention councils and Regional Action

Councils to work with these groups should be explored.

Smoking cessations programs are generally limited as are programs in the schools beyond health class. Recent initiatives from the Department of Public Health concerning innovative programming for housing authorities and youth access to tobacco may provide opportunities to address tobacco issues.

According to the Priority Ranking Matrix completed by CNAW Tobacco ranked sixth overall of the eight substances/behaviors being considered. This is a considerable drop in priority from previous years. The CNAW believes that this is due to the change in laws banning public smoking, increase in the cost of products, and general culture change. While the health effects will continue to be seen for many more years, there is the potential for new generations to be less involved in tobacco use.

Marijuana

Magnitude

According to data based on the 2008,2009 and 2010 NSDUH national surveys, the South Central CT region significantly exceeds rates for the use of marijuana in the past year compared to national, northeastern U.S., Connecticut state and the five RAC regions. The rates for the 12-25 year old population reach almost 41%.

	12-17 years of age	18-25 years of age	26 or older	18 or older
Total U.S.	13.67	29.42	7.65	10.86
Northeast U.S.	14.48	34.28	8.24	11.99
CT	16.22	36.86	8.78	12.67
South Central	18.85	40.48	9.75	14.08

Source: NSDUH, Marijuana Use in Past Year
Table 9

From the same data source, marijuana use in the past month for the region is not the highest in the state in every age group compared to the five regions, but it is still higher than state, northeastern U.S. and national levels and the majority of the sub regions.

Perceptions of risk have been shown to influence behavior and the NSDUH 2008-2010 data measuring the perceptions of great risk from smoking marijuana once a month correlates with the data on past use. South Central ranks lowest in the perceptions of harm from marijuana in the 12 to 17 and 26 and older age categories when compared to the nation, northeast U.S., CT as a whole and the five regions (the North Central CT region ranks lower in perception of harm in the 18-25 year old category).

Anecdotal information from the CNAW notes the widespread perception by youth that marijuana is legal (based on an erroneous understanding of the decriminalization of small amounts) and now marijuana is a prescribed drug in CT. Students in the middle school have repeatedly state that cigarette smoking is unhealthier and a greater risk that smoking marijuana.

Consequences

Smoking marijuana frequently has been associated with increased reporting of health problems and more days of missed employment than nonsmokers. In the short-term marijuana use may cause adverse physical, mental, emotional, and behavioral changes such as problems with memory and learning, distorted perception, difficulty in thinking and problem solving, loss of coordination, and increased heart rate. Longer-term adverse health effects include respiratory illnesses, memory impairment, and weakening of the immune system. Long-term marijuana use causes changes in the brain similar to those seen after long-term use of other major drugs of abuse.

Marijuana has been shown to compromise the ability to learn and remember information, often leading to deficits in accumulating intellectual, job or social skills. Depression, anxiety, and personality disturbances have been associated with marijuana use. Babies born to women who used marijuana during their pregnancies display altered responses to visual stimuli, increased tremulousness, and potential neurological problems. The risk of heart attack more than quadruples in the first hour after smoking marijuana. Initiation of marijuana use at younger ages has been linked to higher and more severe patterns of use of marijuana and other substances in adolescence and adulthood.

Overall school attendance in the sub region is very close to or above the state attendance rate, however school suspension rates for illegal drug related incidents do account for a loss of academic time. Data from 2006-2011 provide the percentage of school suspensions due to the use of illegal drugs.

% of all suspensions attributed to illegal drugs	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
CT	**34%**	**37%**	**39%**	**35%**	**43%**
SCCSAC	**32%**	**33%**	**33%**	**33%**	**48%**
Branford	67%	38%	28%	11%	43%
East Haven	88%	29%	23%	22%	43%
Guilford	13%	59%	62%	43%	67%
Hamden	62%	24%	26%	14%	64%
Madison	32%	17%	50%	8%	18%
Meriden	25%	67%	30%	43%	52%
No. Branford	33%	15%	15%	36%	53%
No. Haven	70%	6%	35%	25%	55%
Wallingford	33%	61%	25%	39%	37%
ACES Coop	*	7%	37%	54%	36%

CT Tech HS	*	39%	23%	64%	61%
Highville	0%	0%	0%	0%	0%

Source: CT State Dept. of Education Table 10

Capacity

According to the priority-ranking matrix completed by the CNAW, marijuana ranks third overall in the assessment of substances/behaviors that were studied.

The widespread use of the drug, the intergenerational cultural acceptance of use, the low perception of harm and the mixed societal messages have been noted as factors affecting the ability to change the use patterns of marijuana.

A statewide group of prevention and substance abuse professionals has begun meeting to address the concerns of the implementation of medical marijuana in the state. The SSCSAC region has several active participants in this group.

Several PFS grantees have chosen marijuana as their second substance to address after underage alcohol use.

Prescription Drug Misuse

Magnitude

Nonmedical use of pain relievers in the past year annual averages based on the 2008,2009 and 2010 NSDUH surveys:

	12-17 years of age	18-25 years of age	26 or older	18 or older
Total U.S.	**6.42**	**11.74**	**3.48**	**4.70**
Northeast U.S.	5.31	11.86	3.06	4.32
CT	**4.87**	**10.36**	**2.71**	**3.78**
Eastern	5.68	10.32	2.84	4.14
No. Central	4.08	9.42	2.33	3.29
Northwestern	5.82	11.92	3.27	4.39
South Central	**5.22**	**10.95**	**2.85**	**3.98**
Southwest	4.27	9.61	2.52	3.43

Source: NSDUH Table 11

Although lower than national averages, the South Central region of CT exceeds the overall averages for CT nonmedical use of pain relievers in all age categories.

Anecdotal comments from treatment providers, school personnel, patents and high school students confirm that the misuse of pills of all types is occurring in the sub region. Incidents of the practice of mixing various pills in bowl (bowling, farming) and then indiscriminately taking several of the pills have been reported in several towns. The over-prescribing by physicians was noted with a concern that teens are being prescribed narcotics by oral surgeons as well.

CNAW participants noted that in prior years tobacco and alcohol were viewed as “gateway” drugs. Increasingly school surveys and prevention professionals are noting that marijuana and prescription medications are acting as “gateway” drugs.

Consequences

One precursor to heroin use has been shown to be the use of opiates in other forms including most notably pills such as OxyContin. The access to the pills and the high relatively quick addiction potential can lead the abusers to move to heroin which is often less expensive than the pills.

Although not all drug arrests are due to prescription pill use/abuse and the behaviors they cause, the growing number of medication abusers has added to the arrest data in the sub region. The drug arrest rate for the SCCSAC region as a whole runs slightly below the rates posted for the entire state from 2005-2010. The city of Meriden consistently reports a higher than state average for drug arrests in the ages of 10 and above.

The rate for arrests in the 18-24 year old category shows that most towns have trended downward although a few have increased in the rate of arrests. The data for 2010 is uniformly low and more information is needed to completely understand why the large drop is seen across the entire region.

	2007	**2008**	**2009**	**2010**
CT	**254.0**	**261.0**	**255.4**	**257.8**
SCCSAC	**284.2**	**246.3**	**224.3**	**233.7**
Branford	130.0	188.4	298.9	168.9
East Haven	138.4	205.0	189.6	92.3
Guilford	160.6	149.9	74.9	160.6
Hamden	213.6	177.3	178.8	31.5
Madison	103.4	280.6	103.4	14.8
Meriden	546.5	400.9	341.8	112.8
No. Branford	501.9	363.9	363.9	40.6
No. Haven	218.9	297.1	164.2	47.7
Wallingford	250.1	177.0	184.7	41.3

Source: CT Dept. of Emergency Services and Public Protection Uniform Crime Reporting Program. Rates given per 100,000 population Table 12

School suspensions for pharmaceutical related incidents have made up a small percentage of suspensions when compared to alcohol, illegal drugs and tobacco violations. The overall CT statewide rate for pharmaceutical related suspensions has fluctuated. Of the towns that have suspensions due to pharmaceuticals the number of school systems

have grown from 3 in 2006 to impacting 5 school systems in 2010.

% of suspensions	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
CT	**3%**	**3%**	**4%**	**8%**	**4%**
SCCSAC	**2%**	**3%**	**2%**	**2%**	**5%**
East Haven	4%			4%	4%
Guilford	8%	5%			
Madison	7%	6%	5%	4%	
CT Tech HS System		11%		9%	14%
Meriden		7%	7%		3%
Hamden			3%		
Area Coop. Educ. Serv.				8%	36%
Wallingford				3%	
Branford					3%

Source: CT State Dept. of Education Table 13

Capacity

According to the Priority Ranking Matrix completed by the CNAW prescription drug misuse is ranked as number 2 overall of the eight substances/behaviors that were studied. Prescription drug misuse scored the highest in impact to the community. Treatment providers and parents of youth noted the correlation between prescription drug misuse and later heroin addition repeatedly.

Medication Take Back programs and Medication Drop Box programs have begun in several towns in the region. The programs allow community members to safely dispose of all prescription and over the counter medications. The intent of the program is to remove narcotic and abuseable medications from homes where there is unmonitored access by persons who would experiment and/or abuse these products. The programs also educate the general public to the dangers of prescription medication abuse.

A program to reach community and school athletic coaches with information for parents on prescription medication abuse has begun in the sub region.

Parent education programs such as the Teen Influencer and Pact360 have begun in the sub region.

A parent led group has started in the Wallingford area due to the overwhelming number of young people who have overdosed in the past few years. The cause of the overdoses is heroin or prescription medication combinations.

Heroin

Magnitude

CNAW members began discussing growing concerns with the impact of heroin in the region beginning in 2008. Their concerns were not unfounded. The region has shown a consistent increase in the number of deaths due to drug use. Current data suggest that heroin is indeed a significant health threat in all towns and cities in the region. The rise in the abuse of prescription opiates has led to the increase of younger addicts who transition from pills to powdered heroin, either smoked or snorted and finally injected. The purity of the heroin available in the state has led to keep addicts in the state "loyal" to the product. National information and data from state assigned Drug Enforcement agents point to CT as being a "heroin" state as opposed to many other states in the country who have been impacted by methamphetamine trafficking.

Consequences

Heroin is a highly addictive drug and its abuse has repercussions that extend far beyond the individual user. Addiction is the most detrimental long-term effect of heroin use because it is a chronic, relapsing disease characterized by compulsive drug seeking and use.

Treatment providers have reported that they have seen an increase in the number of younger people addicted to heroin, and they have been presenting for treatment with more complex medical issues. Heroin is a highly addictive drug with consequences including HIV/AIDS, tuberculosis, fetal effects, crime, violence and disruption of family, work and school. Chronic use can lead to fatal overdose, vein damage, bacterial infections, heart damage, liver and kidney disease.

Although not all drug-induced deaths are caused by heroin, a significant number of drug users progress from other drugs of abuse (prescription medication such as OxyContin).

Reported by number/crude rate per 100,000 several of the towns in the region exceed the statewide rates of death by drugs. While any death by overdose is a concern, the data shows that all towns and cities in the region are affected with some of the towns consistently above the state and regional averages. The majority of towns have shown an increase in deaths due to drugs from 1999-2009.

	1999-2001	2002-2004	2005-2007	2007-2009
CT	980/9.6	1200 /11.4	1200 /11.4	1195 /11.4
SCCSAC	**91/**	**99/**	**113/**	**112/**
Branford	11/12.8	**14/16.3**	11/12.8	10/11.6
East Haven	9/10.6	**19/22.5**	**19/22.5**	**15/17.7**
Guilford	5/7.8	2/3.1	4/6.2	4/6.2
Hamden	13/7.6	9/5.3	**22/12.9**	**18/10.6**
Madison	2/3.7	2/3.7	3/5.6	3/5.6
Meriden	**29/16.6**	**23/13.2**	**37/21.2**	**37/21.2**
No. Branford	4/9.6	3/7.2	4/9.6	4/9.6
No. Haven	8/11.5	9/13.0	2/2.9	6/8.7
Wallingford	**10/7.7**	**18/13.9**	**11/8.5**	**15/11.6**

Source: CT Dept. of Public Health Table 14

In a study conducted by researchers from Brown University data from 1997-2007 indicates that drug overdoses in CT are the leading cause of adult injury death, more that deaths due to motor vehicle accidents, fire, and firearms combined.

Capacity

According to the Priority Ranking Matrix completed by the CNAW heroin ranked fourth overall. Heroin was ranked sixth by the 2010 CNAW.

SCCSAC and community members participated in a CDC sponsored research project addressing opiate-involved deaths in two CT towns. Wallingford/Meriden was identified as having an emerging problem with overdose deaths. A Community Advisory Board met for a year and identified promising initiatives to adopt. One program was the expansion of training and possession of Naloxone/Narcan. Trainings for community and family members as well as education on the expanded CT Good Samaritan law have begun in the region. The research team has recently been contacted to have them return to the Community Advisory Board to present their final report and update the committee.

A parent led group has started in the Wallingford area due to the overwhelming number of young people who have overdosed in the past few years.

The cause of the overdoses are heroin or prescription medication combinations. Heroin is seen as readily available and of lower cost than other opiate based substances.

Cocaine

Magnitude

Cocaine use in the past year data is based on annual averages from 2008-2010 NSDUH surveys. Data is available for the entire South Central region that includes Greater New Haven and the Lower Naugatuck Valley towns.

	12-17 years old	18-25 years old	26 or older	18 or older
Total U.S.	**1.07**	**5.19**	**1.48**	**2.03**
Northeast U.S.	1.05	6.32	1.78	2.44
CT	**1.18**	**5.25**	**1.35**	**1.89**
Eastern	*	4.62	1.29	1.87
No. Central	1.12	4.99	1.23	1.73
Northwestern	1.40	5.85	1.46	2.03
South Central	**1.17**	**6.04**	**1.46**	**2.10**
Southwest	1.10	4.55	1.31	1.72

Source: NSDUH Table 15

* Low precision; no estimate reported

According to NSDUH data from 2009-2010, cocaine use in CT peaks dramatically in the 18 to 25 year old age level. When coupled with the data on usage of other substances, the 18-25 year old population is at high risk for addiction and overdose and treatment efforts are needed to target that population.

	Ages 12+	Ages 12 – 17	**Ages 18-25**	Ages 26+	Ages 18+
Past Year Cocaine Use	1.69	1.04	**5.13**	1.21	1.76

Source: NSDUH Table 16

Cocaine users are one of many addicts whose use of illicit drugs leads them to seek treatment. According to data from NSDUH surveys from 2008-2010 sorted by age, those needing treatment but not receiving it in the past year, the South Central region is slightly higher than the state average in all age groups.

	Ages 12-17	Ages 18-25	Ages 26 or older	Ages 18 or older
U.S.	4.28	7.16	1.52	2.35
Northeast U.S.	4.15	7.95	1.51	2.44
CT	**4.03**	**7.56**	**1.40**	**2.25**
South Central	**4.09**	**7.95**	**1.54**	**2.44**

Source: NSDUH (Percentages) Table 17

Consequences

Negative physical consequences of cocaine use include heart disease, lung damage, renal failure and infections, including HIV and hepatitis B and C.

Psychological consequences of cocaine use include anxiety, depression, suicidal feelings and behavior, insomnia, emotional instability, aggressive behavior and psychotic symptoms.

CNAW participants noted that cocaine use is not mentioned often in the SCCSAC sub region. The use of heroin in all forms is more prevalent.

Capacity

According to the Priority Ranking Matrix completed by the CNAW participants cocaine ranked seventh in the overall ranking of the eight substances/behaviors. CNAW members had little direct knowledge of cocaine use in the region. Prescription drug misuse and heroin are seen as more immediate concerns when considering illicit and misappropriated drugs.

CNAW members discussed the need to focus on other illicit substances that ranked higher in magnitude and impact in the sub region.

Problem Gambling

Magnitude

Little substantive data is available within the sub region on the magnitude of the problem. CNAW members noted that lottery tickets, especially scratch off tickets are popular within the Meriden area. Online gambling and games are common with college students and the assumption is that this will increase as the State looks at legalizing online gambling.

At various times, youth gambling has been addressed in suburban towns. These efforts have been generally in response to groups of youth gambling on poker and sports.

Consequences

According to DMHAS Problem Gambling Service in 2009 the vast majority of people in CT who choose to gamble do so with little or no adverse consequences. However, those who do gambling to excess can face the loss of family, financial assets including homes, businesses and their jobs. National data suggests that compulsive and pathological gambling can lead to a high rate of suicide when the gambler sees no way out of the financial and emotional turmoil that surrounds their addiction.

Gambling impacts the same brain receptors as cocaine and has been classified as a mental health/addiction condition.

Capacity

According to the Priority Ranking Matrix completed by the CNAW participants problem gambling ranked eighth out of the eight substances and behaviors studied.

SCCSAC has a number of problem gambling initiatives active in the sub region and across the State, including coordination of the CT Women and Problem Gambling Project and the Congregation Assistance (CAP) program. Both community education programs focus on the need to understand the role that compulsive gambling plays in the life of an individual and their family. When conducting the CAP trainings for clergy and laypersons two sections are consistently mentioned as “new and surprising “ information that the participants did not previously know/connect as an addiction. These sections are on gambling (number 1) and inhalant abuse (number2).

The link to other addictions cannot be overlooked. CNAW members noted that persons in recovery for substance use have “transferred” their addictions to gambling as a “safer” activity. Family members have stated “at least they (the addict) are not doing drugs anymore.” The need to educate the public on the addictive potential of gambling remains a challenge in the sub region.

South Central CT Substance Abuse Council

Suicide

Magnitude

Data from 1999-2009 collected by the CT Department of Public Health documents the number and rate of suicide in the SCCSAC region.

	Total Number (Crude Rate per 100,000) 1999-2001	2002-2004	2005-2007	2007-2009
CT	854 (8.4)	813 (7.7)	813 (7.7)	867 (8.2)
SCCSAC	74	73	88	71
Branford	6 (7.0)	8 (9.3)	6(7.0)	7(8.1)
East Haven	9 (10.6)	10(11.8)	6(7.1)	4(4.7)
Guilford	5 (7.80)	4 (6.2)	7(10.9)	5(7.8)
Hamden	12 (7.0)	6 (3.5)	15(8.8)	13(7.6)
Madison	0 (0.0)	4 (7.4)	7(7.4)	4(7.4)
Meriden	17 (9.7)	20(11.4)	19(16.6)	23(13.2)
No. Branford	8 (19.2)	3 (7.2)	3(7.2)	1(2.4)
No. Haven	6 (8.7)	8(11.5)	8(11.5)	4(5.8)
Walling-ford	11 (8.5)	10(7.7)	10(7.7)	10(7.7)

Source: CT DPH Mortality Statistics Table 18

With the exception of the town of Madison, every municipality in the sub region has either met or exceeded the state suicide rate for one or more years between 1999 and 2009. Meriden and Wallingford have consistently documented high rates of suicide.

According to NSDUH based on the national surveys from 2008-2010 the data pertinent to the CT region encompassing SCCSAC is:

Had serious thought of suicide in the past year:

	Ages 12-17	Ages 18-25	Ages 26 or older	Ages 18 or older
Total U.S.		6.47	3.30	3.76
Northeast U.S.		6.73	3.29	3.78
CT		6.36	3.45	3.85
Southcentral CT		**6.93**	**3.68**	**4.13**

Source: NSDUH Table 19

Had at least one major depressive episode in the past year:

	Ages 12-17	Ages 18-25	Ages 26 or older	Ages 18 or older
Total U.S.	8.16	8.24	6.32	6.60
Northeast U.S.	7.84	8.22	6.31	6.58
CT	7.79	8.00	5.97	6.25
Southcentral CT	**7.87**	**8.14**	**6.16**	**6.43**

Source: NSDUH Table 20

The data shows that the South Central region exceeds national, regional and state data for the number of persons who have had serious thought of suicide in the past year (2008-2010 estimates by NSDUH). Additionally, the south central region exceeds the CT average of persons who have experienced a major depressive episode in the past year in all age categories. This data is in line with the CT Department of Public Health mortality statistics for the rate of completed suicides.

From 1999 to 2007 suicide has been one of the top leading causes of death for 10-54 year olds in CT, and second for young adults 18-24 in college. (Source AAS, WISQARS)

Consequences

Recent data from work being done in CT cites that for every suicide death there is an estimated 6 survivors who are impacted by the death. (A suicide survivor is someone who has lost a loved one to death by suicide.) This would bring the total number of people in the sub region in need of services much higher than the number provided by the mortality statistics.

Suicide can be linked to substance abuse use, problem gambling and mental health disorders. According to the CDC from 2001-2005, 23% of suicides in CT were attributable to alcohol use.

Capacity

Suicide ranked fifth overall by the CNAW members when considering the eight substances/behaviors in the Priority Ranking Matrix. Although ranked low in Magnitude (number of completed suicides) the Impact of suicide was ranked higher. The CNAW

considered the impact on families, schools and communities when a suicide is completed.

According to suicide prevention data, most people who attempt suicide do not die in their attempt. Youth average 100-200 attempts per 1 completion, with elders having 4 attempts per completion. This data would suggest that intervention/prevention efforts could have a significant impact in reducing both the number of attempts and the number of completed suicides. The sub region is participating in the Connecticut Garrett Lee Smith grant program and a number of prevention and intervention trainings are scheduled in the region. The RAC has certified trainers in the evidence-based QPR and Connect programs and will begin implementation of the trainings in February 2013. Local partners with the RAC are providing Mental Health First Aid Training to further strengthen the capacity of the communities to provide pre and post intervention services.